MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
APPLICATION FORM
ASSISTED HOUSING PROGRAMS

PLEASE COMPLETE AND **RETURN TO:**
Division of Licensing and Regulatory Services
Community Services Programs
State House Station # 11
Augusta, ME 04333

For Agency Use Only	
SBI _____	**County** _____
H_2O _____	**Prog. Spec.** _____
SFMO _____	**H.F.S.** _____
FEE $_____	

1) THIS APPLICATION FORM MUST BE COMPLETE OR THE APPROVAL PROCESS COULD BE DELAYED**.**
2) **RETURN THIS APPLICATION AND RELATED DOCUMENTS, AND *TWO (2) ADDITIONAL COPIES*** TO THE ADDRESS ABOVE.
3) IF APPLYING FOR A LEVEL I, II, III, OR IV RESIDENTIAL CARE FACILITY THE APPLICATION MUST BE ACCOMPANIED WITH A **NON-REFUNDABLE FEE OF $10.00 FOR EACH BED REQUESTED**. IF APPLYING FOR AN ASSISTED LIVING PROGRAM THE APPLICATION MUST BE ACCOMPANIED WITH A **NON-REFUNDABLE FEE OF $200.00**.
4) THE APPLICATION MUST INCLUDE A SEPARATE CHECK ($25.00 PER PERSON) FOR THE APPLICANT, ADMINISTRATOR AND/OR HOUSEHOLD MEMBERS 18 YEARS OR OLDER FOR CRIMINAL HISTORY BACKGROUND CHECK. **MAKE CHECKS PAYABLE TO: TREASURER, STATE OF MAINE**. *THE BACKGROUND CHECK IS WAIVED FOR LICENSED RESIDENTIAL CARE ADMINISTRATORS AND LICENSED MULTI-LEVEL ADMINISTRATORS.*

Projected Opening Date:

FACILITY TYPE APPLYING FOR:

Level I _____ Level II _____ Level III_____ Level IV_____ (See Section 2.49)

Level I (PNMI) _____ Level II (PNMI) _____ Level III (PNMI) _____ Level IV (PNMI) _____
(See Section 2.40)

Assisted Living: Type I _____ Type II _____ (See Section 2.8)

Name of Facility _____

911 Address of Facility _____

Mailing Address of Facility _____ Zip _____

E-Mail Address _____ Phone Number _____ 2nd Phone_____

FAX _____ # of Residential Care Facility Beds Requested _____ # of Assisted Living Units

Requested _____

Directions for Reaching Facility _____

_____

_____

APPLICANT INFORMATION:

CHECK WHAT APPLIES: INDIVIDUAL _____ CORPORATION _____. IF APPLICANT IS A CORPORATION CHECK EITHER PROPRIETARY _____ OR NON-PROFIT _____.
Applicant:

Ms.
Mr. _____
First Middle Last

_____
(**home address**) Street Town State Zip Code

_____
Phone Number Date of Birth Social Security Number OR
IRS Identification Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) _____

Co-Applicant:

Ms.
Mr. _____
First Middle Last

_____
(**home address**) Street Town State Zip Code

_____
Phone Number Date of Birth Social Security Number OR
IRS Identification Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) _____

ADMINISTRATOR / PERSON IN CHARGE:

_____
First Middle Last

_____
(home address) Street Town State Zip Code

_____
Phone Number Date of Birth Social Security Number

INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES) _____

BUILDING OWNERSHIP IDENTIFICATION (if applicable)

Building Ownership, if different from Applicant: (Individual, Partners, Corporation Name, Company Name)

_____
Name Street State Zip Code Main Office Telephone #

Identification Number: _____
(Owner's Social Security Number or IRS Identification Number)

If ownership is a corporation, indicate: Proprietary _____ or Non-Profit _____

If owner is a corporation, list on a separate sheet the names, addresses, and titles of each officer, director, and each person owning 10% or more of the total stock, specifying the percentage of ownership if Proprietary.
If applicant doesn't own the building submit copy of lease agreement with owner.

MEMBERS OF THE HOUSEHOLD (If applicable)

List all persons who are not residents/consumers of assisted housing and who reside in the facility.

Name	Date of Birth	Social Security # (For ages 18 +)	Occupation	Relationship to Applicant

_____

_____

_____

_____

FOR EACH HOUSEHOLD MEMBER INDICATE OTHER NAMES KNOWN BY (I.E., MAIDEN NAME, ALIASES)

_____

_____

Comment on the health of each person in the household listed above, giving special emphasis to any physical or mental limitations._____

_____

Facility Physician and Address: _____

_____

_____

Type of insurance, liability, home owner's etc. (please list)_____

DESCRIPTION OF FACILITY

1. Number of Residential Care Facility bedrooms, beds, and bathrooms available for resident/consumer use:

	Bedrooms	Beds	Bathrooms
First Floor	_____	_____	_____
Second Floor	_____	_____	_____
Third Floor	_____	_____	_____
Basement	_____	_____	_____

2. (Assisted Living Programs)

Number of efficiency units _____
Number of one bedroom units _____
Number of 1+ bedroom units _____

3. Type of Heating: _____

4. Are all windows screened? _____

12. Number of exits from building, including fire escapes: _____

13. Does each bedroom (for residents/consumers) have at least one

5. Sewage system (check one): Municipal _____ Other _____

6. Water Supply (check one): Municipal _____ Other _____

7. Physical Features of the Home (check all that apply):

Stairs to Bedroom ____ Woodstove____ Fireplace____

Wheelchair Ramp____ Handicap accessible ____

Smoke detectors & Extinguishers ____ Intercom System____

Elevator ____

8. Do you allow pets?_____ What kind?_____

9. Do you or other occupants smoke? _____

10. Do you permit residents/consumers to smoke?_____

11. Is kitchen facility on-site?_____ *If no kitchen on-site, where will meals be prepared?*_____

14. Will there be a designated alzheimer's/dementia care unit? _____ (See Section 6)

outside window? _____

TYPE OF POPULATION TO BE ADMITTED: (Check all that apply)

Male___ Female___ Age Range_____

Persons with:
dementia/Alzheimer's disease___
hearing impairments___
physical disabilities___
neurological impairments___
mental health issues ___
mental retardation or developmental disabilities___
sight impairments___
alcohol or drug abuse issues ___
head trauma ___

Persons who are:
wheelchair dependent___
elderly___

LIST ALL HOME HEALTH AGENCIES, REGISTERED PERSONAL CARE AGENCIES, DAY CARE and LONG TERM CARE FACILITIES (including assisted housing programs and nursing homes) owned and/or operated by applicant or spouse:

Address:_____Phone #_____

_____

Address:_____Phone #_____

_____

Address:_____Phone #_____

EDUCATION OF APPLICANT OR CHIEF EXECUTIVE OFFICER OF APPLICANT:

School Name	City/State	Last Grade Completed	Degree	Year

SPECIAL QUALIFICATIONS OF APPLICANT (Enclose Copy of all Pertinent Credentials)

____ Multi-Level Administrator's License ___Residential Care Administrator's License ___ Registered Professional Nurse
____ Licensed Practical Nurse ___ Certified Nurses Aide ___ Certified Residential Medication Aide
____ Sign Language ___ Other Language Spoken _____ ___ CPR
____ Resident Care Specialist I ___ Personal Support Specialist ___ Direct Support Specialist

OTHER RELEVANT EXPERIENCE: Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use reverse side, if necessary)

The following questions are used to help evaluate the safety and security of residents/consumers who will be living in the facility. Issues in the following areas do not automatically mean a license will be denied. (To be answered by applicant or chief executive officer of the applicant)

Have you ever been convicted of a criminal offense? _____

If so, explain. _____

_____

_____

Have you (or the agency, if applicable) ever had a license for any long term care facility denied, suspended or revoked in this state or any other state? _____

If so, by whom. Please explain. _____

_____

_____

Have you or anyone previously listed as a household member been *investigated* for child abuse or adult abuse? _____

If so, explain. _____

_____

_____

Have you ever been treated for drug/alcohol abuse? _____

If so, explain. _____

_____

_____

Have you ever been an inpatient in a mental health facility? _____

If so, explain. _____

_____

_____

The applicant certifies that all information contained in this application is true and correct to the best of my knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I/We, _____, certify to be in compliance with all local laws and ordinances as they relate
(Print Name of Applicant)
to zoning, plumbing. water supply, and sewage disposal. I/We further appoint _____ to assume
(Print Name of Administrator)
responsibility for the day to day conduct of the Assisted Housing Program herein described, and do hereby apply for a license to operate the facility and do agree to assume responsibility that the facility will comply with all the current regulations of the Department of Health and Human Services, as authorized by Title 22, M.R.S.A. s7802. I/We understand that the signing of this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.

If Applicant is an individual or partnership please sign and date below.

Signature of Applicant: _____ Date: _____

Signature of Co-Applicant: _____ Date: _____

If Applicant is a corporation, please sign and date below that you have the legal authority to make this application.

Signature: _____ Date: _____

The following questions are used to help evaluate the safety and security of residents/consumers who will be living in the facility (To be answered by <u>administrator</u> as soon as selected). Issues in the following areas do not automatically mean a license will be denied. Answers may be submitted separate from the application.

Have you ever been convicted of a criminal offense? _____

If so, explain. _____

_____

_____

Have you (or an employer, if applicable) ever had a license for any long term care facility denied, suspended or revoked in this state or any other state? _____

If so, by whom. Please explain. _____

_____

_____

Have you ever been *<u>investigated</u>* for child abuse or adult abuse? _____

If so, explain. _____

_____

_____

Have you ever been treated for drug/alcohol abuse? _____

If so, explain. _____

_____

_____

Have you ever been an inpatient in a mental health facility? _____

If so, explain. _____

_____

_____

TO BE COMPLETED BY ADMINISTRATOR

EMPLOYMENT HISTORY OF ADMINISTRATOR OR PERSON IN CHARGE

Give last five years employment history: (Attach separate sheet if necessary)

Name and Address of Employer	Job Responsibilities	Dates From	To	Reasons For Leaving

EDUCATION OF ADMINISTRATOR:

School Name	City/State	Last Grade Completed	Degree	Year

SPECIAL QUALIFICATIONS (Enclose Copy of all Pertinent Credentials)

____ Multi-Level Administrator's License
____ Registered Professional Nurse
____ Certified Nurses Aide
____ Sign Language
____ CPR
____ Personal Support Specialist
____Residential Care Administrator's License
____ Licensed Practical Nurse
____ Certified Residential Medication Aide
____ Other Language Spoken
____ Resident Care Specialist 1 certified
____ Direct Support Specialist

OTHER RELEVANT EXPERIENCE: Describe previous paid, volunteer, or family experiences or training in working with elderly or disabled populations. (Use reverse side, if necessary)

I certify that all information provided herein is true and correct to the best of my knowledge. I also understand that signing this application effectively serves as a release of information and gives permission to the Department to obtain any criminal history and Bureau of Motor Vehicle record which may be on file in any county or state office.

Signature of Administrator: _____ Date: _____

ADDITIONAL INFORMATION/APPENDICES

IN ADDITION TO THE PREVIOUS PAGES, THE FOLLOWING ADDITIONAL INFORMATION IS NEEDED. PLEASE SUBMIT THE ATTACHED APPENDICES AND INFORMATION INDICATED FOR THE TYPE FACILITY YOU WISH TO OPERATE. FAILURE TO SUBMIT THE REQUIRED INFORMATION WILL DELAY YOUR APPLICATION UNTIL RECEIPT OF THIS INFORMATION.

	Level I	Level II	Level III	Level IV	Assist. Living
Appendix A (References)	X	X	X	X	X
Appendix B (Admission Policy)	X	X	X	X	X
Appendix C (Financial Info.)	X	X	X	X	X
Floor plans or Blueprints of facility	X	X	X	X	X
Policies required by Regulations, Section 10.9.4				X	
Complaint Resolution Procedure, Section 5.8	X	X	X	X	X
Disaster Plan, Section 3.31.6	X	X	X	X	X
If the facility is being leased, provide copy of lease agreement	X	X	X	X	X
Names/Addresses of Board of Directors, if applicable.	X	X	X	X	X

REFERENCES - INCLUDE THREE (3) WRITTEN LETTERS OF REFERENCE FOR THE APPLICANT AND ADMINISTRATOR FROM PERSONS WHO ARE NOT RELATED BY BLOOD OR MARRIAGE. THE QUESTIONNAIRE BELOW NEEDS TO BE COPIED AND GIVEN TO REFERENCES TO COMPLETE.

Reference for Assisted Housing Providers

Referent's Name:_____Applicant/Administrator's Name:_____
Facility Name: _____

Please respond to the questions below. Use the back of this sheet if necessary.

1. How long have you known the applicant/administrator?

2. In what capacity do you know this person?

3. Are you familiar with this person's experiences in serving persons who are elderly or disabled? If yes, please describe.

4. Describe this person's ability to give care and services to persons who are elderly or disabled.

5. Describe this person's strengths and weaknesses in the following areas:
A. Coping with problems and stress.

B. Working with other people

C. Decision making

D. Communication and Listening

F. Ability to work with outside resources such as social workers, medical professionals, state agencies, friends and families of residents, etc.

6. Do you have any concerns about this person's ability to work in an Assisted Housing Program?

7. Do you recommend that this person be given the opportunity to work in or operate an Assisted Housing Program?

Appendix B DIRECTIONS: ALL ASSISTED HOUSING PROGRAMS - You may complete this form or you may submit a narrative which addresses each of these areas**.**

The admissions policy for Assisted Living Programs shall describe who may be admitted and scope of services provided, including scope of Nursing Services, consistent with applicable state and federal law.

Admission Policy

NAME OF HOME: DATE:

PROVIDER NAME:

This is a general statement describing this home and the services it provides: (Description of facility should include accessibility, # of rooms, singles or doubles, first or second floor, smoking/non-smoking, pets, outdoor setup, agency or private owned, setting, description of home, cable TV, telephones, storage of personal belongings, etc. Services available may include transportation, ADLs, supervision, recreational/motivational activities, spiritual, social, educational opportunities.)

This home intends to provide services for persons who have the following care needs (note: Do not list the conditions or persons you will not serve. as this is discriminatory and in violation of federal law.)

List and describe community services available to residents of your home. (social, recreational spiritual, health, educational, volunteer services, shopping)

List and description of the types of staff the home intends to hire. (Resident Manager, cook, book keeping, direct care staff, RN Consultant, volunteers)

Description of training that will be regularly provided to all care providers, including resources to provide training.

Description of accommodations the home has for persons with impairments. (ramps, special bathing equipment, lighting, furniture, # of accessible bathrooms)

Description of steps the home is willing to take to increase accommodations for persons with impairments.

Description of how coordination with medical and other programs/professionals will be accomplished.

Description of specific expertise, training/education, experience of the care providers that qualifies each to deal successfully with the residents/consumers to be served and to create positive living conditions for these residents. (You may attach relevant copies of degrees, certificates, licenses, and other documentation related to the information below.)

Appendix C - DIRECTIONS: TO BE COMPLETED BY LEVEL II, III AND IV RESIDENTIAL CARE FACILITIES AND ASSISTED LIVING PROGRAMS. PROGRAMS WHICH HAVE BUDGETS APPROVED BY DHHS FOR REIMBURSEMENT DO NOT HAVE TO COMPLETE THIS FORM *IF* A COPY OF THE PRO-FORMA (ESTIMATED FINANCIAL BUDGET) IS SUBMITTED.

FINANCIAL INFORMATION

OPERATING PROJECTIONS:

SERVICE EXPENSES

	Annual
Payroll, Taxes & Insurance	
Consultants	
Respite Care	
Respite Care/Vacation	
Insurance - W/C	
On-going Training	
Food	
Telephone	
Entertainment/Activities	
Travel	
Supplies: Household	
Supplies: Hygiene	
Supplies: Office	
Legal/Acctg	
Prof. Insurance	
Misc.	
Other	
Other	
TOTAL SERVICE BUDGET	

CAPITAL EXPENSES

Heat	
Hot Water	
Electric	
Cooking	
Water/Sewer	
Insurance	
Real Estate Taxes	
Rubbish Removal	
Snow Removal	
Repairs	
Replacement Escrow	
Mortgage Payments	
Other Loans	
Other	
TOTAL CAPITAL BUDGET	
plus	
TOTAL SERVICE BUDGET	
TOTAL EXPENSES	

RESOURCES:

RESOURCE	ACCOUNT #	WHERE HELD	AMOUNT
			$
			$
			$
			$
			$

TOTAL RESOURCES $

minus

TOTAL EXPENSES $

BALANCE $

FLOORPLANS

Directions: Sketch the floor plan of the facility, noting location, size and number of resident/consumer bedrooms. Also note other areas designated for resident/consumer use, rooms to be occupied by family members or others who are not residents/consumers, bathrooms, living and dining areas, and exits. You may send printed floor plans or blueprints in lieu of this sketch.